Non-Covered State Medicaid Plan Services Request Form for Recipients *under* 21 Years Old

Definitions of the Federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at:
http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html

This form MUST accompany your Prior Approval request for EPSDT consideration via submission through provider portal, fax or mail. **DO NOT** send this form to NCTracks without an accompanying Prior Approval request. It will not be processed without a Prior Approval Request.

I. **Recipient Information:** This must be completed by a physician, licensed clinician, or other provider.

Name: _____

Date of Birth: _____/_____/_____ (*mm/dd/yyyy*)   Medicaid ID Number: _____

Address:

_____

_____

_____

II. **Medical Necessity:** All requested information, including CPT and HCPCS codes, if applicable, as well as provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name: _____   Provider Name: _____
NPI: _____   NPI: _____
Address: _____   Address: _____

_____   _____

_____   _____

Telephone: (____)____- Fax: (____   Telephone: (____)____- Fax: (____
_____)____-_____   _____)____-_____

Requested procedure,
product or service: _____   CPT/HCPCS code: _____/_____

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the nature of the care.)

_____

What is the recipient's health history? (Include chronic illness.)

_____
_____
_____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and the recipient's current status.)

_____
_____
_____

What treatment has been given for the diagnosis(es) above? (Include previous and current treatment regimens, duration, treatment goals, and the recipient's response to treatment(s).)

_____
_____
_____

Please provide a description of how the requested procedure, product or service will correct or ameliorate the recipient's defect, physical or mental illness, or condition (the problem.) This description _must_ include a detailed discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Is this request for an experimental or investigational treatment? ☐ Yes ☐ No
If yes, provide name and protocol number: _____

Is the requested product, service, or procedure considered to be safe? ☐ Yes ☐ No
If no, please explain. _____
_____

Is the requested product, service or procedure effective? ☐ Yes ☐ No
If no, please explain. _____
_____

Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? ☐ Yes ☐ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available. _____

_____

_____

_____

What is the expected duration of treatment? _____

_____

_____

_____   _____
Requestor's Signature & Credentials   **Date**